

PI - Deficit Reduction Act of 2005, Section 6032: Reviewing Provider Policies

Purpose:

Within the Iowa Medicaid Enterprise (IME), the PI Unit is responsible for monitoring provider compliance with these DRA Section 6032 requirements.

The Deficit Reduction Act of 2005 (DRA) amended the Social Security Act with important requirements related to Medicaid program integrity. Under Chapter Three of the DRA, entitled “Eliminating Fraud, Waste and Abuse,” the US Congress enacted provisions regarding “Employee Education About False Claims Recovery” (Section 6032). Section 6032 of the DRA established Section 1902(a)(68) of the Social Security Act.

Section 6032 of the DRA (Pub. L.109-171) mandates that any provider or provider entity that receives payments, in any federal fiscal year, of at least \$5,000,000 from any state Medicaid program must have written policies for all employees, including management, and for all employees of any contractor or agent, that provide detailed information about the following:

- the Federal False Claims Act under title 31 of the United States Code, sections 3729 through 3733;
- administrative remedies for false claims and statements under title 31 of the United States Code, chapter 38;
- any State laws pertaining to civil or criminal penalties for false claims and statements (Iowa Code 249A.8 and 714.8(10)-714.14);
- whistleblower protections under such laws; and
- the provider or provider entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

These policies may be in written or electronic form, but must be disseminated and readily available to all employees and to all employees of any contractor, or agent, and must be included in any employee handbook of the provider or provider entity. The information required regarding the Federal False Claims Act, federal administrative remedies, state laws, and whistleblower protections is limited to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in title 42 of the United States Code, section 1320a-7b(f)).

The IME, in Provider Informational Letter No. 547, determined it is the responsibility of providers or provider entities to make the determination as to whether they meet the \$5,000,000 threshold.

If providers or provider entities determine that they meet the threshold, they must do the following:

1. Provide the name, address, and National Provider Identification (NPI) provider number(s) associated with each provider or provider entity;
2. Submit copies of written or electronic policies of each provider or provider entity that meet the federal requirements;
3. Provide a written description of how the policies are made available and disseminated to all employees and to all employees of any contractor or agent for each provider or provider entity.

Provider Informational Letter No. 547 instructed affected providers to send this required information to the following address or fax number.

IME Program Integrity (PI)
P.O. Box 36390
Des Moines, IA 50315

Fax the IME PI Unit (515) 725-1354.

Identification of Roles:

IME PI Unit—monitors provider compliance with these DRA Section 6032 requirements.
IME Core Unit—publishes user documentation and training materials for OnBase.

Performance Standard:

N/A

Path of Business Procedure:

Reviewing Provider Submissions of DRA Information

- Step 1. Re-index the DRA documents in OnBase to the “**PI DRA Correspondence**” document type which routes the documents to the **PI00—Deficit Reduction Act** queue. Refer to the procedure titled “**Documents, Processing in OnBase**” for detailed instructions on processing incoming mail and faxes in OnBase.
- Step 2. Keyword **PI DRA Correspondence** in the **PI00—Deficit Reduction Act** queue with the following keywords: Prov Number, Prov NPI Number, and Prov last Fac Name by using the “**Enter Keywords**” task. The IME CORE Unit

Account Manager may be contacted if necessary for OnBase documentation training.

Step 3. This information submitted by providers is reviewed by the Account Manager for compliance with the following:

- a. Information on False Claims Act included.
- b. Information on Administrative Remedies for false claims and statements included.
- c. Information on State laws pertaining to penalties for false claims and statements included.
- d. Information on whistle blower protection included.
- e. Policy and procedure for detecting and preventing fraud, waste, and abuse included.
- f. Information is noted as being included in the employee handbook.
- g. Name, address, and NPI # of providers and/or entities included.

Step 4. The Database Management Administrator constructs an Excel spreadsheet with a list of all providers who submitted DRA information. Save this spreadsheet at [\\dhsime\PI\Deficit Reduction Act\SURS Compliance Procedures and Data](#). On this spreadsheet, document compliance with the guidelines listed in bullet point 3 above. Refer to the spreadsheet [\\dhsime\PI\Deficit Reduction Act\SURS Compliance Procedures and Data\Provider Information Submitted.xls](#) for a template.

Step 5. Send certified letters requesting additional information to providers not compliant with one or more of these guidelines. Examples of letters are found at [\\Dhsime\PI\Deficit Reduction Act\SURS Compliance Procedures and Data\Provider letters](#).

DEFINITIONS

ENTITY – An “entity” includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least \$5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the \$5,000,000 annual threshold

regardless of submission of claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an “entity” (such as, a state mental health facility or school district providing school-based health services). A government agency merely administering the Medicaid program, in whole or part (such as, managing the claims processing system or determining beneficiary eligibility) would not qualify for these purposes.

An entity will have met the \$5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity’s responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

EMPLOYEE – An “employee” includes any officer or employee of the entity.

CONTRACTOR or AGENT – A “contractor” or “agent” includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

Forms/Reports:

Spreadsheet–[\\dhsime\PI\Deficit Reduction Act\SURS Compliance Procedures and Data\Provider Information Submitted.xls](#)

RFP Reference:

6.1.2.2.11

Interfaces:

Program Integrity Unit
Provider Services

Attachments:

None